STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	C 06/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite revisit and complaint investigation was conducted on 06/03/2021. Tags F550, F565, F567, F570, F578, F580, F585, F641, F644, F655, F657, F684, F689, F693, F700, F758, F761, F880 and F883 were corrected as of 06/03/2021. Repeat tags were cited. The facility is still out of compliance. 1 of 6 complaint allegations was substantiated.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to perform weekly skin assessments for 1 of 3 residents reviewed for pressure ulcers. (Resident #10) Findings included: Resident #10 was re-admitted to the facility on 01/08/2021 with diagnoses including diabetes.	F 686	1. The skin assessment for resident #10 was performed and completed on 6-2-2021. 2. A full facility audit on skin checks was performed to ensure that other residents in the facility were having skin checks performed. This audit will be completed by July 7, 2021.	7/7/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/24/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 A review of her quarterly minimum data set assessment (MDS) dated 04/17/2021 indicated she was severely impaired for daily decision making. Resident #10 required the total assistance of one to two people for bed mobility, eating, toileting, bathing and personal hygiene. She was always incontinent of bowel and bladder. The MDS further indicated Resident #10 was at risk for pressure ulcers and had one stage 2 (superficial) pressure ulcer that was not present on admission. She had a pressure relieving device on her bed and pressure ulcer care in place. A review of the current care plan for Resident #10 dated 10/14/2020 and last revised on 04/22/2021 indicated a focus area for diabetes. The goal was for Resident #10 to have no complications related to diabetes through the next review. An intervention included a weekly skin assessment by a nurse. A review of a weekly skin assessment for Resident #10 dated 03/31/2021 indicated she had no new areas of skin breakdown. A review of Resident #10's medical record indicated no further weekly skin assessments documented from 03/31/2021 through 06/01/2021. On 06/02/2021 at 10:14 AM an interview with Wound Care Nurse #1 indicated she was the facility treatment nurse. She stated Resident #10 should be having weekly skin assessments done and documented by a licensed nurse because she was at risk for skin breakdown. She went on to say she did not perform the weekly skin assessments, the floor nurse did those.	F 686	3. The facility nurses were inserviced on the completion of the weekly skin checks for all residents. The nurses were informed that the weekly skin checks were scheduled for the residents and that they were responsible for completing those skin checks. This inservice will be completed by July 7, 2021. 4. An audit will be completed by the DON or their designee to ensure that the weekly skin checks are being performed as scheduled. These audits will be completed weekly x 4 weeks and then monthly x 4 months. 5. The results of these audits will be taken to the facility monthly QA&A meetings to ensure that weekly skin checks are being performed.	

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F 686	Continued From page 2 On 06/02/2021 at 10:15 AM an interview with Nurse #2 indicated she was the floor nurse caring for Resident #10. She stated residents who required a weekly skin assessment had an order for it and the skin assessment screen popped up for the nurse to complete when it was due. She stated she could find no order for weekly skin assessments for Resident #10. She further indicated Resident #10 had no weekly skin assessments documented since 03/31/2021. On 06/02/2021 at 10:52 AM an interview with the director of nursing (DON) indicated she could find no evidence Resident #10 had any weekly skin assessments done from 03/31/2021 through 06/01/2021. She stated Resident #10 should have had these done and documented weekly to promptly identify any new areas of breakdown because she was at risk. The DON went on to say the assistant director of nursing assessed Resident #10's skin on 06/02/2021 and found no new areas of breakdown. On 06/02/2021 at 2:28 PM an interview with MDS Nurse #3 indicated she created the care plan focus area for diabetes for Resident #10. She stated she specifically chose the intervention for weekly skin assessments for Resident #10 because Resident #10 was at risk for skin breakdown. MDS Nurse #3 went on to say if a resident had this intervention on their current care plan, nurses should be following through. On 06/02/2021 at 3:28 PM an interview with the administrator indicated he was not sure why the facility continued to have an issue with the completion and documentation of weekly skin assessments for residents who had the	F 686		

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F 686	Continued From page 3 intervention on their care plan. He stated the facility had done a random audit to make sure this was being done and had not found any problems.	F 686		